State of Maine
Department of Health and Human Services
11 State House Station
Augusta, Maine
04333-0011

John Elias Baldacci
Governor

John R. Nicholas
Commissioner

July 13, 2004

TO: Interested Parties

FROM: Christine Zukas-Lessard, Acting Director, Bureau of Medical Services

SUBJECT: Proposed Rule: Chapters II & III, Section 85, Physical Therapy Services of the MaineCare Benefits Manual.

This letter gives notice of a proposed rule: Chapters II & III, Section 85, Physical Therapy Services of the MaineCare Benefits Manual. This rule implements a legislative deappropiation in MaineCare physical therapy services for adults.

Chapter II of the rule updates all sections to current MaineCare requirements. Adults must meet specific eligibility guidelines and then are limited in the physical therapy services available.

Chapter III establishes new billing procedure codes based on HIPPA compliant CPT coding.

Rules and related rulemaking documents may be reviewed at and printed from the Bureau of Medical Services website at http://www.maine.gov/bms/MaineCareBenefitManualRules.htm or, for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. The TDD/TYY number is 1-800-423-4331.

A concise summary of the proposed rule is provided in the Notice of Proposed Rulemaking. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Proposed Rulemaking.

Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, Bureau of Medical Services

RULE TITLE OR SUBJECT: Chapters II & III, Section 85, Physical Therapy Services of the MaineCare Benefits Manual.

PROPOSED RULE NUMBER:

CONCISE SUMMARY: This rule proposes major changes in coverage of MaineCare Physical Therapy Services. The rule, when adopted, will implement a legislatively mandated reduction for MaineCare Physical Therapy Services. This rule will establish specific eligibility criteria for adults and set limitations on the services they may receive. Eligibility for adults will be limited to those with rehabilitation potential and to treatment following certain hospital stays, after certain procedures, and in cases of required extensive assistance in activities of daily living, and to other medically necessary treatment. Additional changes include revisions to billing procedure codes necessary to update MaineCare billing codes to current coding practice.

SEE http://www.maine.gov/bms/MaineCareBenefitManualRules.htm FOR RULES AND RELATED RULEMAKING DOCUMENTS.

THIS RULE WILL __ WILL NOT _X_ HAVE A FISCAL IMPACT ON MUNICIPALITIES.

STATUTORY AUTHORITY: 22 M.R.S.A., § 42, § 3173, § 3174-FF

PUBLIC HEARING:

Date: August 11, 3:00 PM
Location: Conference Room # 1A
Department of Health and Human Services
442 Civic Center Drive
Augusta, ME

Any interested party requiring special arrangements to attend the hearing must contact the agency person listed below before August 4, 2004.

DEADLINE FOR COMMENTS: Comments must be received by midnight August 23, 2004

AGENCY CONTACT PERSON: Kip Neale, Comprehensive Health Planner
AGENCY NAME: Bureau of Medical Services
ADDRESS: 442 Civic Center Drive
11 State House Station
Augusta, Maine 04333-0011

TELEPHONE: 207-287-9361 FAX: (207) 287-9369 TTY: 1-800-423-4331 or 207-287-1828 (Deaf or Hard of Hearing)

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SECTION 85 **PHYSICAL THERAPY SERVICES** 7/1/79

68.01 PURPOSE

The purpose of this rule is to provide medically necessary physical therapy services to MaineCare members who are adults (age twenty-one (21) and over) with rehabilitation potential and medically necessary physical therapy services to MaineCare members who are under age twenty-one (21).

85.0~~1~~2 DEFINITIONS

85.0~~1~~2-1 Physical Therapy practitioner means an individual who is licensed as a physical therapist or licensed as a physical therapy assistant working under the supervision of a licensed physical therapist.

85.0~~1~~2-2 Physical Therapy services ~~means services prescribed by a physician or oral surgeon and provided to a recipient by or under the supervision of a licensed physical therapist in accordance with Title 32, Chapter 45-A, Physical Therapist Practice Act and as described in this Section.~~ means services prescribed by a physician, oral surgeon, or the member's primary care provider (PCP) and provided by or under the supervision of a licensed physical therapist for the purposes of evaluating a member's condition, and planning and implementing a program of purposeful services to develop or maintain adaptive skills necessary to achieve the maximum physical and mental functioning of the member in his or her daily pursuits.

85.0~~1~~2-3 Rehabilitation potential is the documented expectation of measurable functionally significant improvement in the member's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan. The physician's documentation of rehabilitation potential must include the reasons used to support the physician's expectation.

85.0~~1~~2-4 Functionally significant improvement is the demonstrable measurable increase in the member's ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment.

85.0~~1~~2-5 Maintenance therapy means physical therapy services provided to a member whose condition is stabilized after a period of treatment or for whom no further functionally significant improvement is expected.

85.0~~2~~3 ELIGIBILITY FOR CARE

Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to providing services, as described in Chapter I.

~~The following recipients are eligible for physical therapy services as set forth in this manual:~~

85.0~~2~~3 **ELIGIBILITY FOR CARE** (Cont.)

~~A. Categorically Needy Medicaid Recipients, whose eligibility is shown on the Medical Eligibility Card as MM, and~~

~~B. Medically Needy Medicaid Recipients, whose eligibility is shown on the Medical Eligibility Card as MI.~~

85.0~~3~~4 **SPECIFIC ELIGIBILITY FOR CARE**

Services for members of all ages must be medically necessary. The Department or its authorized agent has the to right perform eligibility determination and/or utilization review to determine if services provided were medically necessary.

Adult members (age twenty-one (21) and over) must have rehabilitation potential documented by a physician or PCP. Adult members are specifically eligible only for:

1. Treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities; and/or

2. Treatment after a surgical procedure performed for the purpose of improving physical function; and/or

3. Treatment in those situations in which a physician or PCP has documented that the patient has, in the preceding thirty (30) days, required extensive assistance in the performance of one or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility; and/or

4. Medically necessary treatment for other conditions including maintenance and palliative care, subject to the limitations in Section 85.07.

85.0~~3~~5 **DURATION OF CARE**

~~Each Title XIX recipient is eligible for as many~~ Ceovered services ~~as are~~ must be medically necessary and must not exceed the~~,~~ ~~subject to the~~ limitations ~~specified~~ set in Section 85.0~~5~~07. The Department or its authorized agent reserves the right to request additional information to evaluate medical necessity.

85.0~~4~~6 **COVERED SERVICES**

MaineCare will reimburse for covered medically necessary services in all outpatient settings, including the home. Services must be of such a level, complexity, and sophistication that the judgment, knowledge, and skills of a licensed therapist are required. All services must be in accordance with acceptable standards of medical practice and be a specific and effective treatment for the member's condition. Services related to activities for the general good and welfare of members (for example, general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation) are not MaineCare covered physical therapy services.

85.0~~5~~6 **COVERED SERVICES** (Cont.)

~~The following services are covered when provided by a physical therapist in an appropriate setting.~~MaineCare reimburses providers for the following physical therapy services:

~~C.~~85.0~~5~~6-1 Evaluations ~~(test and measurements) Services~~or re-evaluations: Evaluation services are covered ~~as defined below:~~for members under age twenty-one (21). For adults, evaluations are covered services only if required by a physician or PCP to document the member's rehabilitation potential.

~~1. Orthotic "checkout" - Concerned with checking the physician's prescription for the fit and functions of an orthotic appliance or appliances (splints, braces, other assistive devices).~~

~~2. Prosthetics "checkout" - Concerned with checking the physician's prescription for the fit and function of a prosthetic appliance (artificial limb).~~

~~3. Functional evaluation (activities of daily living) - Consists of testing ability to perform activities related to self-care in the home, in common transportation, and in job situation.~~

~~4. Manual muscle testing - The relative strength of individual or groups of skeletal muscles as compared with accepted norms is determined.~~

~~5. Range of motion and girth measurements - Goniometric measurements of a specific joint or joints and circumference measurements of a specific body segment or segments are taken.~~

~~6. Electrical testing - Any one of a series of tests given to determine specific activity of nerve or muscle strength-duration, (Jolly Test).~~

~~A.~~85.0~~5~~6-2 Modalities: Modalities are covered services. Modalities are any physical agents applied to produce therapeutic changes to biologic tissues; including but not limited to thermal, acoustic, light, mechanical, or electric energy. Except when performing supervised modalities, the therapist is required to have direct (one-on-one) continuous patient contact.

~~1. Hot or cold packs~~

~~2. Mechanical traction~~

~~3. Electrical stimulation~~

~~4. Ultrasound~~

~~5. Vasopneumatic devices~~

85.0~~5~~6 **COVERED SERVICES** (Cont.)

~~6. Paraffin bath~~

~~7. Microwave~~

~~8. Whirlpool~~

~~9. Diathermy~~

~~10. Infra-red~~

~~11. Ultraviolet~~

85.0~~5~~6-3~~B~~. Therapeutic Procedures: Therapeutic procedures are covered services. Therapeutic procedures effect change through the application of clinical skills and/or services that attempt to improve function. The therapist is required to have direct (one-on-one) continuous patient contact to provide therapeutic procedures.

~~1. Neuromuscular re-education~~

~~2. Functional activities~~

~~3. Gait training (Does not mean ambulation activity)~~

~~4. Orthotics training~~

~~5. Prosthetics training~~

~~6. Electrical stimulation (Motor Point)~~

~~7. Iontophoresis~~

~~8. Manual traction~~

~~9. Massage~~

~~10. Contrast baths~~

85.0~~5~~6-4 Tests and measurements: Tests and measurements are covered services. The therapist is required to have direct (one-on-one) continuous patient contact in performing testing and measurement.

~~D.~~85.0~~5~~6-5 Collateral ~~Services~~Contacts: Collateral Contacts are covered services. Collateral ~~services~~ contacts are face-to-face contacts on behalf of a ~~recipient~~ member by a therapist to seek information or discuss the ~~recipient's~~ member's case with other professionals, caregivers, or others

85.0~~5~~6 **COVERED SERVICES** (Cont.)

included in the treatment plan in order to achieve continuity of care, coordination of services and the most appropriate mix of services for the ~~recipient~~member. Discussions or meetings between staff of the same agency or clinic (or contracted agency or clinic), are not considered collateral contacts, unless such discussions are part of a team meeting that includes other professionals and care givers who are not employed by the same agency or clinic but ~~who~~ are included in the development of the treatment plan. The billing provider may only request reimbursement for one servicing provider per collateral contact. For purposes of these rules, school administrations are not considered agencies or clinics.

~~E.~~85.0~~5~~6-6 Supplies

Supplies are covered services. Providers may bill for supplies necessary for the provision of physical therapy services. Covered ~~S~~supplies under this section include ~~are such~~ items such as splinting. Providers may not bill for supplies under other Sections of the MaineCare Benefits Manual, unless they are enrolled as providers and comply with the appropriate Section requirements. Covered supplies under this Section must be billed at acquisition cost and be documented by an invoice in the member's file. Routine supplies used in the course of treatment are not separately reimbursable. Take-home supplies are not reimbursable. ~~and not supplies covered under other Sections of the Maine Medical Assistance Manual. Supplies must be billed at acquisition cost and be supported by an invoice.~~

85.0~~5~~07 **~~LIMITATIONS~~LIMITED SERVICES**

85.07-1 Age under twenty-one (21):

~~Reimbursement will not be made for less than 15 minutes or for more than two hours of services per day, with the exception of collateral services provided on the same day therapy is provided.~~

MaineCare will not reimburse for physical therapy services provided at the same time as other therapies are being provided, i.e. co-therapy, unless those other services are developmental therapy services. Furthermore, to be reimbursed for this co-therapy, physical therapy services must be in the member's plan of care, performed under the guidance of Child Development Services and coordinated with the provision of developmental therapy being provided under the Early Intervention Section of the MaineCare Benefits Manual, Chapter II, Section 27. For both the physical therapy provider and the developmental therapist who provides the one-on-one therapy, it must be in the plan of care that both providers are necessary for the effective delivery of service.

85.~~05~~07 **~~LIMITATIONS~~LIMITED SERVICES** (Cont.)

85.07-2 All ages:

A. MaineCare will not reimburse for more than two (2) hours of physical therapy services per day, with the exception of collateral contacts provided on the same day therapy is provided. In no instance may collateral contacts exceed one (1) hour per condition.

B. Supervised modalities (those without direct one-to-one continuous contact) that are provided on the same day as modalities requiring constant attendance or on the same day as any other therapeutic procedure are not billable. Billing for supervised modalities as stand-alone treatment is limited to one (1) unit per modality per day.

C. Services for sensory integration are limited to a maximum of two (2) visits per year.

85.07-3 Adults (age twenty-one (21) and over):

A. Services for adults who meet the specific eligibility requirements in Section 85.04 must be initiated within sixty (60) days from the date of physician or PCP certification.

B. Services for palliative care and maintenance care of function are limited to one (1) visit per year to design a plan of care, train the member or caretaker of the member to implement the plan or to reassess the plan of care.

C. Services for adults with documented rehabilitation potential who do not meet the criteria in 85.04(1)-(3) must be medically necessary as documented by a certification by a physician or PCP. Such treatment is limited to no more than one (1) visit per condition by qualified staff.

85.08 **NON-COVERED SERVICES**

Note: Refer to Chapter I of the MaineCare Benefits Manual for additional non-covered services, including academic, vocational, socialization or recreational services.

85.~~6~~09 **POLICIES AND PROCEDURES**

85.~~06~~09-~~3~~1 Qualified Professional Staff

All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body.

85.~~06~~09 **POLICIES AND PROCEDURES** (Cont.)

All professional staff must provide services only to the extent permitted by licensure. The following professionals are qualified professional staff:

Physical therapist
Physical therapy assistant

A physical therapist may be self-employed or employed by an agency or business. Agencies or businesses may enroll as a provider of service and bill directly for services provided by qualified staff. A physical therapy assistant may not enroll as an independent billing provider.

~~In order to be reimbursable, professional staff must meet the following requirements:~~

~~A. Physical Therapist is an individual who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent; and licensed by the State of Maine or the State or Province in which the service is provided.~~

~~B. Physical Therapist Assistant means a person who assists in the practice of physical therapy and is licensed by the Maine Board of Examiners in Physical Therapy as documented by written evidence from such Board. A licensed Physical Therapist Assistant must work under the direct supervision of a licensed Physical Therapist.~~

85.~~06~~08~~9~~1~~2~~ Member's Records

Providers must maintain a specific record for each member, which shall include, ~~Records must include,~~ but ~~need~~ not necessarily be limited to:

A. Member's ~~N~~name, address, birthdate, and ~~Medicaid~~ MaineCare ID number ~~of patient;~~.

B. ~~Signed specific physician's or oral surgeon's orders~~The member's social and medical history and diagnoses~~;~~.

C. A personalized plan of service including (at a minimum):~~care with specific goals in relation to the total plan of care by physician;~~

1. Type of physical therapy needed;

2. How the service can best be delivered, and by whom the service shall be delivered;

3. Frequency of services and expected duration of services;

85.~~06~~9 **POLICIES AND PROCEDURES** (Cont.)

4. Long and short range goals;

5. Plans for coordination with other health service agencies for the delivery of services;

6. Any medical supplies for which a physician or primary care provider's order is necessary ; and

7. Physician or primary care provider's orders.

The physician or primary care provider must review, sign and date the member's plan of care at least once every three (3) months. The plan of care must be kept in the member's record and is subject to Departmental review along with the contents of the member's record.

D. Written ~~P~~progress notes shall contain:~~for each service delivered relating to the established goals, the time spent in delivering the service, and signed by the physical therapis;t~~

1. Identification of the nature, date, and provider of any service given;

2. The time spent delivering the service;

3. Any progress toward the achievement of established long and short range goals;

4. The signature of the service provider for each service provided; and

5. A full account of any unusual condition or unexpected event, including the date and time when it was observed and the name of the observer.

Entries are required for each service billed. When the services delivered vary from the plan of care, entries in the member's record must justify why more, less, or different care than that specified in the plan of care was provided.

~~E. Periodic physician or oral surgeon's review and sign-off on plan of care not more than every three months.~~

85.09-3 Utilization review

85.~~06~~09 **POLICIES AND PROCEDURES** (Cont.)

The Department or its authorized agent has the right to perform utilization review. If at any point of an illness or disabling condition, it is determined that the expectation for measurable functionally significant improvement will not be realized, or if they are already realized and no more services are needed, the services are no longer considered reasonable and necessary, and will not be covered.

85.0~~6~~9-~~2~~4 Surveillance and Utilization Review

Requirements of Surveillance and Utilization Review are detailed in Chapter I of the MaineCare Benefits Manual.

~~A. Surveillance and Utilization Review monitors the medical services provided and determines the appropriateness and necessity of the services. This monitoring is done to ensure the appropriate quality, quantity, and necessity of services reimbursed by the Department.~~

~~B. The Department and its professional advisors regard the maintenance of adequate clinical records as essential for the delivery of quality care. In addition, providers should be aware that the clinical records are key documents for post-payment reviews. In the absence of proper and complete clinical records, no payment will be made and payments previously made may be recovered in accordance with the appropriate Section in Chapter I regarding "Overpayments".~~

~~C. The Department expects that clinical records and other pertinent information will be transferred, upon request and with the client's signed release of information, to other providers.~~

~~D. Upon request, the provider must furnish to the Department, without additional charge, the clinical records, or copies thereof, corresponding to and substantiating services billed by that provider.~~

85.0~~7~~10 **REIMBURSEMENT**

The amount of payment for services rendered shall be the lowest of the following:

~~A~~1. The amount listed in Chapter III, Section 85, "Allowances for Physical Therapy Services" of the ~~Maine Medical Assistance Manua~~MaineCare Benefits Manual.

~~B~~2. The lowest amount allowed by the Medicare ~~Part B~~ carrier.

~~C~~3. The provider's usual and customary charge.

85.0~~7~~10 **REIMBURSEMENT** (Cont.)

~~D. Physical therapy providers, when furnishing covered services as described in 85.01 and 85.04, shall be reimbursed for interpreter services provided to Medicaid recipients when these services are necessary to communicate effectively with the recipient regarding health care needs.~~

~~Providers of interpreter services must be certified by the Registry of Interpreters for the Deaf, Inc., or working under the supervision of an interpreter who is certified by the Registry of Interpreters for the Deaf, Inc. Reimbursement will be available for an Interpreter's hourly minimum charge and beyond this first hour, reimbursement is based on the quarter hour including associated travel to and from the location where the services are performed.~~

~~Additional reimbursement for deaf Medicaid recipients who have non-standard signing, is available consisting of a relay interpreting team including a deaf interpreter, for whom signing is his/her native language, working with a hearing interpreter. In such cases, reimbursement for two interpreters will be made.~~

~~Reimbursement will be at the Interpreter's usual and customary charge not to exceed the amounts listed in Chapter III of this Section.~~

~~When requesting reimbursement for Interpreter Services, a statement of verification regarding the interpreter's certification and cost of performing the services shall be documented in the recipient's record.~~

In accordance with Chapter I of the ~~Maine Medical Assistance Manual~~MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of a rendered service prior to billing ~~the Medical Assistance Program~~MaineCare.

85.~~0~~811 **COPAYMENTS**

Note: Requirements regarding copayment disputes and exemptions are contained in Chapter I of the MaineCare Benefits Manual.

~~85.08-1 Copayment Amount~~

A. A copayment will be charged to each ~~Medicaid~~ MaineCare ~~recipient~~ member receiving services, with the exception of those exempt, as specified in the MaineCare Eligibility Manual. The amount of the copayment shall not exceed $2.00 per day for services provided, according to the following schedule:

85.~~08~~11 **COPAYMENTS** (Cont.)

~~Medicaid~~ MaineCare Payment for Service	~~Recipient~~ Member Copayment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 or more	$2.00

B. The ~~recipient shall~~member is ~~be~~ responsible for copayments up to $20.00 per month whether the copayment has been paid or not. After the $20.00 cap has been reached, the ~~recipient~~ member ~~shall~~ will not be required to make additional copayments and the provider ~~shall~~ will receive full ~~Medicaid~~ MaineCare reimbursement for covered services.

~~C. No provider may deny services to a recipient for failure to pay a copayment. Providers must rely upon the recipient's representation that her or she does not have the cash available to pay the copayment. A recipient's inability to pay a copayment does not, however, relieve him/her of liability for a copayment.~~

~~D. Providers are responsible for documenting the amount of copayments charged to each recipient (regardless of whether the recipient has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.~~

~~85.08-2 Copayment Exemptions:~~

~~No copayment may be imposed with respect to the following services:~~

~~A. Family planning services and supplies;~~

~~B. Services furnished to individuals under twenty-one (21) years of age;~~

~~C. Services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, nursing facility, ICF-MR, or other medical institution, if that individual is required, as a condition of receiving services in that institution, to spend for costs of medical care all but a minimal amount of his or her income required for personal needs;~~

~~D. Services furnished to pregnant women, including services provided during the three months following the end of a pregnancy;~~

~~E. Emergency services, i.e., when failure to provide the service could reasonably be expected to:~~

~~1. place the recipient's health in serious jeopardy,~~

85.~~08~~11 **COPAYMENTS** (Cont.)

~~2. cause serious impairment to bodily functions, or~~

~~3. cause serious dysfunction of any bodily organ or part.~~

~~F. Services furnished to an individual of a Health Maintenance Organization in which he or she is enrolled.~~

~~G. Recipients in State custody.~~

~~H. Services furnished to any individual who is a resident of a boarding home or foster home.~~

~~Medicaid recipients exempt from copayment requirements are identified by a "NO" in the copay column on the recipient's Medical Eligibility Card.~~

~~See Section 85.09 for billing instructions for copayment exemptions.~~

~~85.08-3 Copayment Exemption Appeals~~

~~If a recipient believes that he or she is exempt from a copayment, disputes the amount of the copayment, or has been denied a service for failure to make a copayment, he or she may contact the Department for assistance in resolving that dispute. Complaints should be directed to the Assistant Director, Bureau of Medical Services at 287-2674.~~

85.~~08~~12 **BILLING INSTRUCTIONS**

A. ~~Billing must be accomplished in accordance with the Department's Billing Instructions for the HCFA 1500 Claim form.~~Providers must bill in accordance with the Department’s billing instructions for the HCFA 1500 claim form.

~~B. In order to receive full Medicaid reimbursement for claims submitted for a service that is defined as an exemption in Section 85.08-2, the diagnosis code "EMR" must be included in addition to the primary diagnosis.~~

~~C~~B. All services provided on the same day ~~shall~~ must be submitted on the same claim form ~~for Medicaid reimbursement~~.

SECTION 85 PHYSICAL THERAPY SERVICES 7/1/79

MaineCare coverage of Physical Therapy Services is limited. Refer to Chapter II, Section 85.06 for specific limitations.

~~ALLOWED AGE~~ Age Group Covered	PROC CODE	DESCRIPTION	MAXIMUM ALLOWANCE	PRIOR AUTH.
ALL AGES	Y9490	PHYSICAL THERAPIST UP TO 15 MIN.	$10.80*	
ALL AGES	Y9489	COLLATERAL SERVICES UP TO 15 MINUTES	$10.00	
ALL AGES	PTA01	PHYSICAL THERAPIST ASSISTANT SERVICES UP TO 15 MIN.	$10.00	
ALL AGES	PTA02	PHYSICAL THERAPIST ASSISTANT SERVICES UP TO 30 MIN.	$20.00	
ALL AGES	PTA03	PHYSICAL THERAPIST ASSISTANT SERVICES UP TO 45 MIN. (INCLUDING TESTS AND MEASUREMENTS)	$30.00	
ALL AGES	PTA04	PHYSICAL THERAPIST ASSISTANT SERVICES UP TO 1 HR. (INCLUDING TESTS AND MEASUREMENTS)	$40.00	
ALL AGES	PTA05	COLLATERAL SERVICES BY PHYSICAL THERAPIST ASSISTANT UP TO 15 MINUTES	$10.00	
~~ALL AGES~~	~~Y9486~~	~~INTERPRETER SERVICES (One hour, during normal business hours)~~	~~$30.00~~	
~~ALL AGES~~	~~Y9487~~	~~INTERPRETER SERVICES (One hour, during non business hours)~~	~~$40.00~~	
~~ALL AGES~~	~~Y9488~~	~~INTERPRETER SERVICES (1/4 hour)~~	~~$ 7.50~~	
ALL AGES	Y9485	SUPPLIES FOR PHYSICAL THERAPY SERVICES	BY REPORT	

In the near future the HIPAA compliant procedure codes below will replace the codes above. The Department will notify providers thirty (30) days in advance.

CODE	SERVICE	UNIT	ALLOWANCE
97001	Physical Therapy Evaluation	15 minutes	$ 10.80
97002	Physical Therapy Re-evaluations	15 minutes	$ 10.80
	THERAPEUTIC MODALITIES SUPERVISED		
97010	Application of a modality to one or more areas; hot or cold packs	15 minutes	$ 10.80
97012	Traction, mechanical	15 minutes	$ 10.80
97014	Electrical Stimulation (unattended)	15 minutes	$ 10.80
97016	Vasopneumatic devices	15 minutes	$ 10.80
97018	Paraffin bath	15 minutes	$ 10.80
97020	Microwave	15 minutes	$ 10.80
97022	Whirlpool	15 minutes	$ 10.80
97024	Diathermy	15 minutes	$ 10.80
97026	Infrared	15 minutes	$ 10.80
97028	Ultraviolet	15 minutes	$ 10.80
	THERAPEUTIC MODALITIES CONSTANT ATTENDANCE		
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	15 minutes	$ 10.80
97033	Iontophoresis, each 15 minutes	15 minutes	$ 10.80

97034	Contract baths, each 15 minutes	15 minutes	$ 10.80
97035	Ultrasound, each 15 minutes	15 minutes	$ 10.80
97036	Hubbard tank, each 15 minutes	15 minutes	$ 10.80
	THERAPEUTIC PROCEDURES		
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 minutes	$ 10.80
97112	Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception for sitting and/or standing activities	15 minutes	$ 10.80
97113	Aquatic therapy with therapeutic exercises	15 minutes	$ 10.80
97116	Gait training (includes stair climbing)	15 minutes	$ 10.80
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	15 minutes	$ 10.80
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	15 minutes	$ 10.80
97504	Orthotic(s) fitting and training, upper extremity(ies) lower extremity(ies), and/or trunk, each 15 minutes	15 minutes	$ 10.80
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes	15 minutes	$ 10.80
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	15 minutes	$ 10.80
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training,) direct (one-on-one) patient contact by the provider, each 15 minutes	15 minutes	$ 10.80
97533	Sensatory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by provider, each 15 minutes	15 minutes	$ 10.80

97535	Self/care/home management training (e.g. activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes	15 minutes	$ 10.80
97542	Wheelchair management/propulsion training, each 15 minutes	15 minutes	$ 10.80
	ACTIVE WOUND CARE MANAGEMENT		
97601	Removal of devitalized tissue from wound, selective debridement, without anesthesia (e.g. high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instructions(s) for ongoing care, per session	*15 minutes*	$ 10.80
97602	Non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic abrasion), including topical applications(s), wound assessment and instructions(s) for ongoing care, per session	15 minutes	$ 10.80
	TESTS AND MEASUREMENTS		
97703	Check out for orthotic/prosthetic use, established patient, each 15 minutes	15 minutes	$ 10.80
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes	15 minutes	$ 10.80
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes	15 minutes	$ 10.80
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device	15 minutes	$ 10.80
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with patient; first hour	15 minutes	$ 10.80
97608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with patient; each additional 30 minutes	15 minutes	$ 10.80

	MUSCLE AND RANGE OF MOTION TESTING		
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk	15 minutes	$ 10.80
95832	Muscle testing, manual (separate procedure) with report; extremity - hand, with or without comparison with normal side	15 minutes	$ 10.80
95833	Muscle testing, manual (separate procedure) with report; – total evaluation of body, excluding hands	15 minutes	$ 10.80
95834	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk – total evaluation of body, including hands	15 minutes	$ 10.80
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)	15 minutes	$ 10.80
95852	Range of motion measurements and report (separate procedure); each extremity – hand, with or without comparison with normal side	15 minutes	$ 10.80
	CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS (e.g. NEURO-COGNITIVE, MENTAL STATUS, SPEECH TESTING)		
96110	Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report	15 minutes	$ 10.80
96111	Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report – extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments (e.g., Bayley Scales of Infant Development) with interpretation and report, per hour.	15 minutes	$ 10.80

	BURNS, LOCAL TREATMENT		
16020	Dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small	15 minutes	$ 10.80
16025	Dressings and/or debridement, initial or subsequent; without anesthesia, medium (e.g., whole face or whole extremity)	15 minutes	$ 10.80
16030	Dressings and/or debridement, initial or subsequent; without anesthesia, large (eg. more than one extremity)	15 minutes	$ 10.80
	MUSCULOSKELETAL SYSTEM		
29105	Application of long arm splint (shoulder to hand)	15 minutes	$ 10.80
29125	Application of short arm splint (forearm to hand); static		$ 10.80
		15 minutes	
29126	Application of short arm splint (forearm to hand); dynamic		$ 10.80
29130	Application of finger splint; static	15 minutes	$ 10.80
29131	Application of finger splint, dynamic	15 minutes	$ 10.80
29200	Strapping, thorax	15 minutes	$ 10.80
29220	Strapping, low back	15 minutes	$ 10.80
292240	Strapping; shoulder (eg. Valpeau)	15 minutes	$ 10.80
29260	Strapping; elbow or wrist	15 minutes	$ 10.80
29280	Strapping; hand or finger	15 minutes	$ 10.80
29505	Application of long leg splint (thigh to ankle or toes)	15 minutes	$ 10.80
29515	Application of short leg splint (calf to foot)	15 minutes	$ 10.80

29520	Strapping; hip	15 minutes	$ 10.80
29530	Strapping; knee	15 minutes	$ 10.80
29540	Strapping, ankle and/or foot	15 minutes	$ 10.80
29550	Strapping; toes	15 minutes	$ 10.80
29580	Strapping; Unna boot	15 minutes	$ 10.80
29590	Dennis Browne splint strapping	15 minutes	$ 10.80
	NERVOUS SYSTEM		
64550	Application of surface (transcutaneous)neurostimulator	15 minutes	$ 4.29
	MEDICINE		
90901	Biofeedback training by any modality	15 minutes	$ 10.80
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	15 minutes	$ 10.80
94667	Manipulation of chest wall, such as cupping, percussing, and vibration to facilitate lung function, initial demonstration and/or evaluation	15 minutes	$ 10.80
94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function, initial demonstration and/or evaluation-subsequent	15 minutes	$ 10.80
95875	Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)	15 minutes	$ 10.80
	PHYSICAL MEDICINE AND REHABILITATION		
97542	Wheelchair management/propulsion training, each 15 minutes	15 minutes	$ 10.80

	COLLATERAL CONTACTS		
Y9489	Collateral contacts	15 minutes	$ 10.00